CONTINUITY OF CARE BETWEEN MEDICAL PROFESSIONALS AND BEHAVIORAL HEALTH PROVIDERS TO PREVENT SUICIDE IN ALASKA

By

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Abstract

This literature review describes the need for continuity of care between medical professionals and behavioral health providers for patients who are experiencing suicidality, highlighting the state of Alaska specifically. An initiative proposal advocating for mandated continuity of care for patients who are experiencing suicidality is included, as well as letters of sponsorship and support which can be sent to various Alaskans in order to advocate for those in need of services. Sending letters of support to a cross-section of Alaskans would ensure that concerns and support are heard from a diverse population of Alaskans. There currently is no act or law which requires continuity of care between medical professionals and behavioral health providers for patients who are experiencing suicidality. This proposal initiative and accompanying letters would be the first step in pursing legal change mandating continuity of care between medical professionals and behavioral health providers in the state of Alaska.

Keywords: suicide, continuity of care, counseling, medical professionals, behavioral health providers

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Continuity of Care between Medical Professionals and Behavioral Health Providers to Prevent Suicide in Alaska

Alaskans need to be made aware of the impact of continuity of care for people who are experiencing suicidality, specifically shared clients of medical professionals and behavioral health providers. Suicide rates, outlined in the literature review to follow, underscore the high number of deaths by suicide in Alaska (American Foundation for Suicide Prevention, 2017; Goldstream Group & Information Insights, 2015). The literature review also provides a brief overview of Indigenous peoples of Alaska historical and continuing trauma, medical professionals' suicide assessments and continuity of care.

A suicide prevention needs assessment was conducted in regards to the Fairbanks North Star Borough (FNSB) area in Alaska (Goldstream Group & Information Insights, 2015). This report noted a survey consisting of 650 participants from the FNSB, 66.9% of which believed that support from medical and mental health providers is very important in preventing suicide. The report also stated that surveyed individuals identified medical assistance as a community resource for those contemplating suicide (Goldstream Group & Information Insights, 2015). Therefore, it is imperative that medical professionals conduct effective suicide assessments, and do everything in their professional ability to prevent suicide.

According to the State of Alaska Suicide Prevention Plan, 2018 – 2022 presented by Fishel and Walker (2017), the goal is for Alaskans to have access to suicide prevention, treatment and other services immediately. One of the strategies includes getting community health providers to provide crisis services to Alaskans close to their home, and as quickly as possible. Methods suggested include behavioral health centers and hospitals making referrals and/or informing Alaskans of resources. For those who live in rural areas, there is a Rural

Aftercare Coordinator who provides continuity of care for Alaskans returning to rural communities. The Rural Aftercare Coordinator role assists the person in successfully following their discharge plan (Fishel & Walker, 2017). There were no additional details within the plan regarding the job description of the Rural Aftercare Coordinator. Also, there was no explicit plan for continuity of care between medical professionals and behavioral health providers.

The Advisory Board on Alcoholism and Drug Abuse (ABADA), Alaska Division of Behavioral Health (ADBH), and Alaska Mental Health Board (AMHB; 2011) wrote a report summarizing comments from a public forum and meetings with Fairbanks stakeholders. Gaps in the system of care in Fairbanks were noted, including aftercare services. The report noted that communication between providers was necessary in order to address gaps in services. A Community Action Planning group has held quarterly meetings, however, attendance was optional. There were other community collaborations as well, however, those were also optional in regards to agency participation (ABADA, ADBH, & AMHB, 2011).

Furthermore, there was difficulty in continuity of care for patients receiving treatment from the Fairbanks Community Behavioral Health Center and other providers (ABADA, ADBH, & AMHB, 2011, p. 10). Providers reported frustration in attempts to share client information and coordinate care and noted being denied access to receive and provide important information due to HIPAA, despite client consent to release information. Knesper (2011) summarized the importance of continuity of care well:

> Saving lives depends on how well 'the chain of survival' functions. This 'chain' has a sequence, beginning with prompt access to care and ending with the provision of definitive care, referral, prompt follow-up, and rehabilitation. Weak or missing links in the sequence result in suboptimal outcomes (p. 25).

Alaska is missing links in its continuity of care that may be causing "suboptimal outcomes" of suicide. There is a need to fill the gaps in continuity of care for patients who are experiencing suicidality in Alaska, linking patients to resources that could be life-saving. Based on evidence within literature, as well as state and local surveys of Alaskans, the research question for this project is two-fold, "What is an effective continuity of care protocol for Alaska residents who complete a suicide assessment indicating a high risk of suicide?" and "How can a continuity of care protocol be implemented into healthcare organizations in the state of Alaska?"

This project will review the effectiveness of continuity of care protocols within various states and communities for people who are at immediate risk for suicide. A focus is placed on reviewing continuity of care practices between medical professionals and behavioral health providers. The impact on suicide reduction as a result of continuity of care will be noted. Exploration was completed on how continuity of care protocols can be effectively implemented within the state of Alaska, highlighting the legislative process. An initiative proposition requesting an act mandating continuity of care between medical professionals and behavioral health providers in Alaska is included. This initiative outlines continuity of care protocols, funding sources, and penalties for non-compliance. Three letters of support are also included to aid in the initiative application process by requesting sponsorship and petition signatures.

Literature Review

The literature review to follow will begin with an overview of suicide, including its definition and statistics on worldwide, national, state, and local levels. These statistics provide numerical evidence of the lives lost to suicide. Focus is placed on the state of Alaska, including a brief summary of the historical trauma Indigenous peoples of Alaska have experienced, influencing past and current suicide rates. Treatment for patients who identify as suicidal,

including aftercare, is discussed, including highlights of medical professionals' suicide assessments. Lastly, continuity of care is explained and examples of its effectiveness in suicide prevention is presented.

Suicide

The Centers for Disease Control and Prevention (2018) defines *suicide* as, "death caused by self-directed injurious behavior with an intent to die as a result of the behavior" (p.1). The World Health Organization (2016), states that approximately 800,000 people around the world commit suicide annually. This total does not include those who have attempted suicide but were unsuccessful, which may be a much higher number (World Health Organization, 2016). People commit suicide at all ages; however, for those ages 15 to 29 years-old, suicide is statistically their second leading cause of death. The most common methods of suicide on a global level are pesticides, hanging and firearms. Although suicide is a serious problem worldwide, it is preventable (World Health Organization, 2016).

On a national level, approximately 44,193 United States citizens die annually by suicide (American Foundation for Suicide Prevention, 2017). This statistic makes suicide the tenth leading cause of death in America, with an average of 121 suicidal deaths daily. In regards to U.S. citizens 15 to 24 years of age, they had a suicide rate of 12.5 in the year 2015, making their rate of suicide lower than all other age groups (American Foundation for Suicide Prevention, 2017). The most common methods of suicide were similar to global statistics, with the top three being firearms, suffocation and poisoning. Almost half of suicides were completed with the use of a firearm, making it the most popular method (American Foundation for Suicide Prevention, 2017).

The state of Alaska has the second highest suicide rate in the nation (American Foundation for Suicide Prevention, 2017). The rate of suicidal death per 100,000 people in Alaska is 26.83, with 201 deaths in the year 2015. Suicide is the leading cause of death among people ages 10 to 24 years old, and the fifth leading cause of death overall in the state (American Foundation for Suicide Prevention, 2017). The Fairbanks North Star Borough (FNSB), located in the interior of Alaska, has a population of approximately 100,000 (Goldstream Group & Information Insights, 2015). In the FNSB there have been 11-27 suicides each year between the years 2005-2014, with the year 2014 consisting of 22 suicides. Similar to global and national statistics, the use of a firearm was the most common method used for suicides (Goldstream Group & Information Insights, 2015). As saddening as these high number of suicidal deaths in Alaska are, it is not surprising given the historical and ongoing trauma of Indigenous peoples of Alaska.

Responses to trauma can encompass specific risk factors for suicide. According to the National Institute of Mental Health, the main risk factors for suicide are:

- Depression, other mental disorders, or substance abuse disorder
- Certain medical conditions
- Chronic pain
- A prior suicide attempt
- Family history of a mental disorder or substance abuse
- Family history of suicide
- Family violence, including physical or sexual abuse
- Having guns or other firearms in the home
- Having recently been released from prison or jail
- Being exposed to others' suicidal behavior, such as that of family members, peers, or celebrities (National Institute of Mental Health, 2017).

By examining the rates of various social, mental health, and behavioral concerns resulting from historical trauma experienced by Alaska Native people, one becomes aware that multiple risk factors for suicide are prevalent, both in the past and presently.

Indigenous Peoples of Alaska and Historical Trauma

Indigenous peoples of Alaska have experienced generational historical trauma since the colonization by non-Indigenous people to Alaska, resulting in an extremely high rate of suicide among the Indigenous Alaskan population. This trauma stemming from colonization began between 1820 and 1840, almost 200 years ago (Morgan & Freeman, 2009). Russia was the first colonizing country to arrive in Alaska, followed by England in 1847. These strangers brought sicknesses with them, to which the Indigenous peoples of Alaska had not been exposed to or immunized against. Indigenous Alaska populations of entire villages died from these illnesses, especially along coastal villages. Koniag and Aleut peoples' population decreased by 20% and other coastal inhabitants decreased by 50% (Morgan & Freeman, 2009). The initial contact with colonizers resulted in a high death toll for Indigenous peoples of Alaska, and continues to influence their death rates via suicides.

As if bringing fatal sickness was not enough, the foreigners colonizing in Alaska deemed it necessary to "civilize" the Indigenous peoples (Morgan & Freeman, 2009). It was determined that in order to "civilize" Indigenous Alaskans, Indigenous Alaska peoples' culture, languages and religious beliefs must be eliminated. The colonizers attempted to accomplish this "civilization process" by removing Indigenous Alaska peoples' children from their homes (sometimes through kidnapping) and placing them in boarding schools (Morgan & Freeman, 2009; Wexler, 2009). Note, this forced schooling took place as recently as the 1970s (Wexler, 2009). In these schools, Indigenous peoples of Alaska's children were denied contact with their families, and instructed that all of their traditional ways were wrong. Plus, children who tried to continue their traditional customs, including speaking their native language, were punished severely (Morgan & Freeman, 2009; Wexler, 2009).

These children of Indigenous peoples of Alaska who were forced into boarding schools away from their homes, families, and culture, eventually became parents themselves (Morgan & Freeman, 2009; Wexler, 2009). However, given their traumatizing, culturally isolating upbringing, these new Indigenous Alaskan parents did not understand the culture and customs of Indigenous peoples of Alaska. Furthermore, they were not raised with appropriate parental figures as examples, so they often lacked guidance in their own parenting. As Alaska legally became a part of the United States, the Indigenous peoples of Alaska cultural oppression continued (Morgan & Freeman, 2009). For instance, upon becoming a state, Alaska village councils were unable to continue to enforce rules for alcohol consumption in their communities, due to no state laws against alcohol importation (Berman, 2014). It was not until a wave of violence connected to alcohol and recurring appeals from villages that Alaska legislation passed laws granting villages options for alcohol distribution. Nevertheless, alcohol abuse continues to be a concern for Indigenous peoples of Alaska and is recognized as a factor in many Indigenous peoples of Alaska suicides (Berman, 2014). The oppression from colonization caused a rise in suicide risk factors; specifically mental health issues, alcohol abuse, and violence among Indigenous peoples of Alaska, which continues to this day (Axelsson, Kukutai, & Kippen, 2016; Berman, 2014; Morgan & Freeman, 2009; Lewis & Myhra, 2017; Wexler, 2009; Sullivan & Brems, 1997).

This modern day oppression of Indigenous peoples of Alaska may not always be as obvious as it was historically (Wexler, 2009). The domination of systems and ways of thinking which reflect Western values instead of the values of Indigenous peoples of Alaska, is the most prevalent (Wexler, 2009). The forced acculturation of Indigenous Alaskan people has resulted in cultural and psychological breakdown for many Indigenous peoples of Alaska (Lewis & Myhra,

2017; Sullivan & Brems, 1997). According to a report published by the Alaska Bureau of Vital Statistics (2018), in 2014 the rate of death by suicide for Indigenous Alaskan males was four times the national average, with 50.9 suicides per 100,000. The trauma of the past has continued to oppress and lead to suicides in the present.

Although the actions and consequences of the past cannot be altered, the future is full of possibilities for healing and change. One way that Indigenous Alaskan peoples' historical trauma and resulting suicidality can be effectively addressed is through integrated care. Lewis and Myhra (2017) define integrated care as the inclusion of behavioral health into medical care, noting that it results in a review of multiple areas and systems of a patient's life. This review can include an examination of how historical trauma has had a negative effect on the Indigenous person's life. Furthermore, integrated care has been shown to increase continuity of care among Indigenous populations (Lewis & Myhra, 2017). This increase may be due to integrated care's ability to provide services that aligns with the health beliefs of patients who are Indigenous peoples, rather than solely Western beliefs. Integrated care resulting in continuity of care is therefore a significant way that patients who are experiencing suicidality can be helped.

Patient Treatment for Suicidality

The initial approach for treating a patient who is experiencing suicidality may differ, depending on the presenting concern. For instance, patients are more likely to be treated immediately for suicidality if they are in an emergency department for an attempted suicide, versus if they visit their primary care physician for a physical aliment. Nevertheless, all medical professionals should be aware of suicide warning signs and consider them with all patients (Hooper, Epstein, Weinfurt, DeCoster, Qu, & Hannah, 2012). The American Association of Suicidology (2018) suggests remembering the warning signs of suicide with mnemonic device,

"IS PATH WARM." The letters in order represent: ideation, substance abuse, purposelessness, anxiety, trapped, hopelessness, withdrawal, anger, recklessness, and mood changes (American Association of Suicidology, 2018). If the medical professional believes that the patient may be suicidal, a simple suicide screening can be completed. Some screenings can be as short as asking three questions, such as the Columbia-Suicide Severity Rating Scale (Substance Abuse and Mental Health Administration, 2018). If patients answer positively for suicidality, a more in-depth suicide assessment can be completed.

Medical Professionals and Suicide Assessment

Primary care medical providers are in a matchless position to assess for suicidality in patients (Chesin, & Stanley, 2013; Gangwisch, 2010; Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014; Hooper, Epstein, Weinfurt, DeCoster, Qu, & Hannah, 2012; Niven, 2007; Vannoy, Fancher, Meltvedt, Unützer, Duberstein, & Kravitz, 2010). These medical professionals can actively help to prevent suicide by performing effective suicide assessments. A major concern, however, is that primary care practitioners are not routinely conducting suicide risk screenings (Chesin, & Stanley, 2013; Gangswich, 2010; Hooper et al., 2012). The reasons behind this lack of frequency are often practitioner reported lack of time, training, and concern of unintentionally increasing patient suicidality (Gangswich, 2010).

In a study conducted by Tsai, Lui, Chang, and Chou (2011), a Gatekeeper Suicide-Awareness Program (GSAP) proved to be beneficial among nurses in a hospital in Taiwan. The results of their study indicated that nurses who participated in the 90-minute GSAP were more aware of suicidal warning signs in a patient and more willing to refer a patient who is experiencing suicidality to counseling than those who did not complete the training. This response was seen by the results of questionnaires given before and after the GSAP was

presented. The control group, which did not participate in the GSAP, overlooked suicide warning signs that those in the experimental group, who attended the GSAP, noted. The experimental group also showed an increase in willingness to refer patients who are experiencing suicidality to a professional. However, although there was an increase in likely referrals, 38% of the study participants said they would not make a referral. This lack of referral may be due to negative and apathetic attitudes some nurses may have toward patients who are experiencing suicidality (Tsai et. al, 2011). Tsai and colleagues (2011) refer to other studies where nurses felt angry and frustrated at patients who are experiencing suicidality, because although the nurses had strived to help them, the patient still made a suicide attempt (Tsai et. al, 2011). Therefore, it is important not only to use an effective suicide assessment, but also to encourage medical providers to have empathy towards their clients experiencing suicidality.

Competence in identifying a patient's risk for suicide is vital for medical professionals (Grimholt et al., 2014; Hooper et al., 2012; Regehr, Bogo, LeBlanc, Baird, Paterson, & Birze, 2016). Physicians who have received education and training in suicide assessment have seen results of lower suicide rates among patients (Gangwisch, 2010). Therefore, in order to be time efficient yet still effective, brief standardized suicide assessments, combined with empathy and proper framing of questions, should be used by physicians (Gangwisch, 2010; Tsai et. al, 2011; Vannoy, Fancher, Meltvedt, Unützer, Duberstein, & Kravitz, 2010). In addition, suicide risk assessments are essential to determining who needs treatment, referrals, and resources (Gangwisch, 2010; Schulberg, Bruce, Lee, Williams, & Dietrich, 2004; U.S. Department of HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). After identifying levels of suicide risk, the appropriate treatment plan can be established.

Treatment and Aftercare

The type of treatment for a patient who is experiencing suicidality is dependent on multiple factors, including but not limited to suicidal ideation versus a recent suicide attempt, emergency room versus a scheduled medical appointment, and other concerns presented with suicidal ideation. Given the various factors related to determining an effective treatment plan, patients should have a treatment plan tailored to their needs.

For patients who have just made a suicide attempt, the risk that they will attempt suicide again is very high, especially in the near future (Christiansen & Jensen, 2007). Knowing this risk, it is important that patients who have attempted suicide receive treatment immediately. One of the first steps is for the patient to be screened for mental illnesses by a psychiatrist. The psychiatrist should be able to recommend the best course of treatment for the patient, given the high risk for a repeated suicide attempt (Christiansen & Jensen, 2007). It is worth noting that psychiatrists should be using an appropriate assessment tool, which according to a study conducted by Waern, Kaiser, and Renberg (2016), is not always the case. The psychiatrist participants noted making clinical decisions based on a "gut feeling," and impressions based on emotional and implicit information (Waern et al., 2016). Courses of treatment should be based on valid assessments and could include prescribing medication(s), hospitalization, and/or referral to a mental health professional (Gangwisch, 2010; Schulberg, Bruce, Lee, Williams, & Dietrich, 2004). Additionally, medical professionals who work with patients who are experiencing suicidality should have an action plan in place for the patient who is experiencing suicidality to follow upon on discharge, in order to receive appropriate help immediately (Christiansen & Jensen, 2007).

The course for treating patients with suicidal ideation is similar to those with a recent suicide attempt, with the possible exception of presenting concerns. Patients experiencing

suicidal ideation may not be forthcoming with their suicidal thoughts (McCabe, Sterno, Priebe, Barnes, & Byng, 2017). Patients may present with one concern, and then state that they have been experiencing suicidal ideation upon further questioning (McCabe et al., 2017). This evidence again highlights the importance of medical professionals being aware of suicide warning signs and performing effective suicide assessments. Once the severity of the patient's suicidality has been determined, plans for treatment can be determined. These treatment plans may include prescribing medication(s), hospitalization, and/or referral to a mental health professional (Gangwisch, 2010; Schulberg, Bruce, Lee, Williams, & Dietrich, 2004).

Interventions included in the treatment plan for a patient experiencing suicidality should consist of at least two general aspects: short-term stabilization and the patient's mental health concerns and risk factors (Granello, 2010). Short-term stabilization entails preventing the suicidal death of the patient and reaching a state of stability. A patient's mental health concerns and risk factors can be addressed in a setting with a mental health professional. Interventions can then be tailored to the patient's specific needs (Granello, 2010). According to Bagge, Lamis, Nadorff, and Osman (2014), reasons for living (RFL) are an aspect worth incorporating into the treatment plan of a patient who is experiencing suicidality. RFL is defined as reasons for not committing suicide, even though the person is experiencing suicidality (Bagge, Lamis, Nadorff, & Osman, 2014). Patients' RFLs can be integrated into their treatment plans by combining RFLs with interventions such as cognitive therapy, which will help enhance and create more RFLs. Acknowledgement of RFLs, along with identification of a patients individual strengths, can aid in the decline of suicidal thoughts and suicide attempts (Bagge, Lamis, Nadorff, & Osman, 2014).

Granello (2010) notes that intensive follow-up is necessary for helping patients during a suicidal crisis. Follow-up is described as including telephone contacts, case management, and even home visits. A crucial aspect of follow-up, however, is the need for one person to be in charge of coordinating the patient's follow-up (Granello, 2010). This one person should also manage the patient's treatment and ongoing risk assessment. By one individual coordinating various aspects of the patient's treatment, confusion between providers can be avoided, as well as provide consistency for the patient (Granello, 2010). When a patient's life potentially hangs in the balance, it is imperative that confusion in the treatment process is avoided at all costs – hence the significance of continuity of care.

Continuity of Care

According to the Suicide Prevention Resource Center (2013), continuity of care takes place when a care provider communicates important clinical information directly with another care provider. This communication ensures that patients have an easy transition between providers. Haggerty, Roberge, Freeman, and Beaulieu (2013), divide continuity of care into three different types: relational, informational, and management. Relational continuity is the relationship between the patient and the health provider. Informational continuity is the understanding of information from past events. Management continuity is the timely and consistent management of services for the patient between various health providers (Haggerty et al., 2013). Continuity of care has also been described to include clear communication between providers and patients (Renholm, Suominen, Turtiainen, Puukka, & Leino, 2014). Overall, continuity of care is successful when care involving all parties is clear and connected (Renholm, et al., 2014).

Continuity of care is highlighted as an important procedure, as it can be very useful in suicide prevention (Hagen, Hjelmeland, & Knizek, 2017; Suicide Prevention Resource Center, 2013). Concerning people who have been admitted for medical care due to a suicide attempt, 70% do not attend their first outpatient appointment (Suicide Prevention Resource Center, 2013). This lack of attendance is especially concerning given that during the first 30 days following discharge from an inpatient psychiatric unit or emergency department, the risk of another suicide attempt or death is at its greatest (Suicide Prevention Resource Center, 2013). Unsuccessful continuity of care has the potential to result in suicide among vulnerable patients (Hagen, Hjelmeland, & Knizek, 2017).

According to Knesper (2011), emergency departments are a critical part of the continuity of care system because it is the only clinic that accepts all patients. Professionals within the emergency department, therefore, have the greatest opportunity to make appropriate referrals and care maintenance (Knesper, 2011). Furthermore, discharge planning is a crucial aspect in reducing the potential of additional suicide attempts and should include making contact with the patient's family and outside providers (Suicide Prevention Resource Center, 2013). According to the U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012), discharged patients from emergency departments or inpatient units who were treated for suicide risk need continuity of care. This continuity of care includes proactive follow-up and connections to community resources. (U.S. Department of HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

Continuity of care is at higher risk of being unsuccessful during times of transition between organizations; therefore, transition care is vital (Haggerty, Roberge, Freeman, &

Beaulieu, 2013). Transition care should include information for patients regarding what to expect in other environments, available resources, and an emergency plan to help the patient remain safe if in overwhelming distress (Haggerty et al., 2013). Information, especially information written down, empowers patients through involvement and providing a sense of security. Furthermore, successful informational continuity helps patients avoid repeating information to health providers, which can be especially helpful when the patient finds the information embarrassing or disturbing (Haggerty et al., 2013). In addition, the patient's relationship with a provider can be so significant that a patient will see a familiar provider instead of a clinical specialist (Haggerty et al., 2013). This preference of a familiar provider highlights the importance of consistency in patient care. A care coordinator can be especially useful during times of patient transition, as one source describes the care coordinator as the person who advocates for and organizes the patient's care experience (Haggerty, Roberge, Freeman, & Beaulieu, 2013). The patient's care plan is helpful not only in providing the patient with information, but all in communicating patient care needs between providers.

Outpatient follow-up services should be provided ideally within 48 hours of discharge, or at the longest, a week (U.S. Department of HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). Collaboration done between emergency departments and mental health providers can also help ensure the patient is receiving the appropriate level of care, possibly in a variety of ways (U.S. Department of HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). There is a notable need for intervention approaches with a focus on successful transition from in-patient to out-patient services, due to frequent failure to complete recommended post-discharge care (Dekker, 2017). Also, potential alternatives to emergency departments and/or inpatient treatment can be

suggested as an option, including in-home crisis care, same-day mental health services, and quick and consistent follow-up. (U.S. Department of HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

Effective continuity of care has the potential to reduce the use of hospital resources (Renholm, Suominen, Turtiainen, Puukka, & Leino, 2014), including inpatient and emergency services (Cho, Kim, Nam, Kim, Kim, Han, & Park, 2015). Additional potential benefits of continuity of care include better preventative care, a decrease in risk of complications, and more patient compliance and satisfaction (Cho et al., 2015). However, one could say the greatest possible benefit of continuity of care is a patient's life saved from death by suicide.

Examples of Continuity of Care

According to Knesper (2011), "Explicit protocols or algorithms for discharge planning and continuity of care are absent in the United States" (p. 98). Although the general guidelines currently used allows clinicians to use their own individualized professional judgment, it also permits meeting the most basic standards of care. Knesper (2011) describes a few health care systems who are making strides in effective systems-based continuity of care. One example was a multidisciplinary suicide prevention team created in 1983 in Baerum, Norway. This team had three goals to achieve at the one and only hospital in the Baerum area:

> (1) securing for all suicide attempters and their families community aftercare prior to discharge, (2) engaging Bærum's health and mental health professional community in education and supervision pertaining to suicide, and (3) providing prevention services to patients referred to the suicide prevention team (Knesper, 2011, p. 104).

These goals summarize the ideals and expectations of continuity of care. A 12-year study began a year after this team was created, surveying all suicide attempts and completions by Baerum citizens, and the results showed a 54% decline in suicide attempts (Knesper, 2011).

Knesper (2011) also highlights the Georgia State Crisis and Access Line as an example of a continuity of care system. The Georgia Crisis and Access Line (GCAL) is available 24/7 throughout the entire state of Georgia and is toll free (Georgia Crisis and Access Line, 2016). Anyone who called this line would be connected to services relating to a behavioral health crisis, a substance use crisis, and/or an intellectual/developmental disability. These services would be tailored to the caller as best as possible, with searches beginning with services closest to the caller's location. Furthermore, the software used by staff at the GCAL known as Crisis Tech 360, has aided in the quality of their continuity of care. Crisis Tech 360 allows staff to construct clinical information, manage documentations and make electronic referrals to outpatient and inpatient services and crisis stabilization units. The software also permits the GCAL staff to monitor progress and availability of resources immediately, and share information with other agencies (Georgia Crisis and Access Line, 2016).

Continuity of Care in State Legislation

Continuity of care for patients who are experiencing suicidality is not always an optional protocol. The state of Washington has adopted into their legislation a form of continuity of care known as *Less Restrictive Alternative Treatment* (Washington State Legislature, 2017). This law was implemented based on legislation findings that encouragement and structure were needed to help those leaving involuntary mental health inpatient treatment to develop lasting stability (Washington State Legislature, 2017). This *Less Restrictive Alternative Treatment* (LRAT) included services of having a designated care coordinator, intake and psychiatric evaluations,

medication management, an individualized crisis plan, and transition plan (Washington State Legislature, 2017).

Theoretical Orientation

Integrated care, which is necessary for successful continuity of care, views patients from a holistic viewpoint (Lewis & Myhra, 2017). In integrated care, the patient's biological, psychological, spiritual, cultural and social aspects are considered in relation to different systems, such as individual or family (Lewis & Myhra, 2017). The different systems in a patient's life have varying influences. Bronfenbrenner's ecological systems theory provides a clear framework of how context influences an individual's life. This theory states that there are five systems which influence every individual: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Tannenbaum, 2018). The microsystem consists of a person's immediate environment, such as school, work or family. The mesosystem consists of relationships between microsystems, such as how an individual's family members interact with school teachers or employers. The exosystem consists of aspects where the individual does not actively participate, but is still impacted, such as mass media, or legal services. The macrosystem is the larger social and cultural context, and the chronosystem is time, such as sociohistorical conditions (Tannenbaum, 2018).

Continuity of care between medical providers and other health professionals would influence an individual on all of Bronfenbrenner's ecological systems. In the chronosystem, time would possibly be lengthened, due to a suicide attempt prevented. The macrosystem could be changed by a more frequent and open discussion of suicidality. The exosystem could be drastically improved by providing direct resources to patients who are experiencing suicidality, via the medical businesses and local communities. The mesosystem and microsystems could be

changed to save the lives of those countless relationships. Most importantly though, continuity of care would help the individual find help and stay alive.

People from all areas of life can experience suicidality – various socioeconomic statuses, racial backgrounds, sexual orientations, professions, and more (Popadiuk, 2013). Therefore, the issue of death by suicide is one that is relevant to everyone. When a person ends his or her life by suicide, the effects of his or her death is widespread. A death by suicide can impact the deceased person's family, friends, teachers, co-workers, and/or acquaintances (Popadiuk, 2013). The suicidal death can cause intense emotional responses from others for years into the future. Furthermore, the person who completed suicide is no longer able to contribute to society, eliminating the possibility of unique contributions in various areas (Popadiuk, 2013).

Understanding that the suicidal death of one person can influence the lives of many, it becomes crucial that suicide be prevented. Continuity of care between medical professionals and behavioral health providers is an effective way to prevent suicide. Adding continuity of care to the state of Alaska's legislation would be a way to guarantee it takes place. Life-saving continuity of care should not be optional or the protocol vague, rather it should be a mandated process with clear protocols.

Alaska Legislation Process

According to the State of Alaska website regarding Alaska Division of Elections (2016), one method for creating a new law is through an *initiative.* An *initiative* is when a law is presented by the state's constituents instead of those in legislation. The initiative is subjected to several steps before it is even voted on: an application, a petition, and an election. The application is where the initiative is proposed, which is filed with the lieutenant governor for a deposited fee of $100. The application must include the proposed bill, voter signatures, and

initiative committee members. If the application is approved by the lieutenant governor, initiative petitions are distributed throughout Alaska, which are then filed. Finally, assuming the previous steps have been done correctly, the initiative will be placed on a ballot.

Application

In order to ensure that continuity of care is taking place between medical professionals and behavioral health providers, a law should be enacted enforcing a policy for such. The packet attached to the end of this paper contains an initiative proposal advocating for a formal protocol to be implemented to ensure discharging patients who responded positively to a suicide assessment obtain effective outpatient treatment. Although this act would be directed towards medical professionals and behavioral health providers, it would impact everyone in Alaska, as suicide crosses all demographics. The packet attached also includes letters of support and sponsorship to various Alaskans, to aid in bringing the initiative before Alaska legislation.

In order to present a relevant and effective initiative, multiple interviews were conducted with persons who have experience with suicidiology and Alaska mental health. The first interview conducted was with April Foreman (A. Foreman, personal communication, June 21, 2018), an Executive Committee Board Member of the American Association of Suicidology. Foreman works out of Baton Rouge, Louisiana as a suicidologist, advocating especially for veterans not only in her area, but around the country. Foreman stated she has experience implementing Zero Suicide, a suicide prevention initiative, into state legislation. According to Foreman, the first step in ensuring continuity of care takes place between providers for people who are experiencing suicidality is conducting a statewide needs assessment. This report would show that there is in fact a need for continuity of care in order to reduce suicide rates. Alaska has already conducted a statewide needs assessment, and created a state suicide prevention plan (an

aspect Foreman also suggested creating). Alaska's suicide prevention plan advocates for continuity of care among providers for people who are experiencing suicidality, however, there is no detailed plan describing how to reach this goal.

After a statewide needs assessment and strategic plan have been completed, Foreman suggested contacting the various suicide prevention advocacy groups within the state to gather support. Foreman explained that larger, unified support on the topic would be most beneficial when presenting a proposal to state legislation. Alaska currently has multiple suicide prevention advocacy groups, including Alaska Careline, Alaska Division of Behavioral Health, and Alaska Mental Health Trust Authority. Per Foreman's suggestion, it would be ideal to gain support for the proposed initiative from all of these groups. This support would demonstrate a united front on suicide prevention, specifically continuity of care.

In regards to a proposal itself, Foreman suggested including a request for a job position dedicated solely to suicide prevention. This person could help ensure that continuity of care is taking place, as well as other preventative measures of suicide. The salary for this position, as well as other financial costs of continuity of care can be covered by grants. Foreman suggested seeking grants via the Zero Suicide initiative or grants connected to the National Strategy for suicide prevention. When asked how much money would be necessary to implement effective continuity of care, Foreman responded that she determined her budget based on how much money was received and worked from that framework. Therefore, the specific budget amount for the proposed initiative would be dependent on grants received. Foreman noted that because suicide prevention is part of the National Strategy, there are many grants available.

Another interview was conducted with James Gallanos (J. Gallanos, personal communication, June 22, 2018), who served primarily as a grant coordinator for the Alaska

Division of Behavioral Health. Gallanos assisted various organizations like schools, tribal organizations, municipalities, and nonprofit organizations obtain grants. The goal of these grants is to aid in addressing a variety of behavioral health concerns, including suicide. Regarding proposing an initiative for continuity of care, Gallanos noted the importance of screening tools and practicality. Gallanos explained that the screening tool for suicidality should be standard throughout the state, providing examples of the Columbia Suicide Severity Rating Scale (CSSRS) and the Patient Health Questionnaire. The CSSRS and Patient Health Questionnaire are brief, which is beneficial for professionals with busy schedules. Also, by using the same screening tool, Gallanos stated that the same terminology would be used between professionals and clearer understanding would be had by all.

The third interview conducted was with Susan Soule (S. Soule, personal communication, June 29, 2018), who formerly worked for the State of Alaska for 18 years in the mental health field in rural areas, as well as in the area of suicide prevention. Soule was the representative for the National Suicide Prevention Crisis Line for multiple years, and aided in drafting the first National Suicide Prevention Plan. Throughout the interview, Soule noted the difference between rural and urban Alaska populations. In the rural villages of Alaska, there are behavioral health aides – individuals who have completed a certification program in behavioral health. The behavioral health aides communicate with medical professional staff at regional health corporations, based commonly in various "hub villages." Soule commented that the behavioral health aides live in the villages they are serving, which is typically a positive aspect due to established trust. Soule explained that there is still a large amount of mistrust among Alaska Native people toward non-Alaska Native people (S. Soule, personal communication, June 29,

2018). This mistrust is not surprising, given the traumatic past of Alaska Native people in relation to non-Alaska Native people.

In regards to creating an initiative mandating continuity of care between medical providers and behavioral health professionals, Soule stated that it would not be effective for rural areas (S. Soule, personal communication, June 29, 2018). Soule posed the question: who would enforce the law in the remote and rural villages? An alternative solution presented was to make documentation of continuity of care a requirement for obtaining and maintaining grants. Soule explained that would influence agencies that work in regions throughout the state, including rural areas (S. Soule, personal communication, June 29, 2018). The possibility of losing money would likely be more effective than a law that may or may not be enforced.

According to a research project completed by University of Alaska Fairbanks graduate student Jasmin Nickell (Nickell, 2017), writing letters of support can be useful in the initiative proposal process. Nickell suggests including four aspects in letters of support: introduction of self and concern, research to support concern, proposed solution for concern, and appreciative closing (Nickell, 2017). The letters of support for the attached initiative will be based on the format and examples presented by Nickell (2017).

Conclusion

An effective continuity of care protocol for Alaska residents who complete a suicide assessment indicating a high risk of suicide begins with the actions of the medical professional and/or behavioral health provider. All medical professionals should be aware of suicide warning signs and consider them with all patients (Hooper, Epstein, Weinfurt, DeCoster, Qu, & Hannah, 2012). If the medical professional believes that the patient may be suicidal, a simple suicide screening can be completed (Substance Abuse and Mental Health Administration, 2018).

Patients who are experiencing suicidality should then have an action plan created to follow upon on discharge (Christiansen & Jensen, 2007). This plan, as well as treatment interventions being used, should be communicated directly to the patient's other care providers in the process of continuity of care.

Continuity of care should include integrated care that reviews multiple areas and systems of a patient's life (Lewis & Myhra, 2017). Integrated care is an especially important aspect of continuity of care for Indigenous Alaskan people, as it can help combat historical trauma and resulting suicidality (Lewis & Myhra, 2017). Ensuring patients are completing their action plans and are connected to community resources, can be completed by a care coordinator (Haggerty, Roberge, Freeman, & Beaulieu, 2013). The care coordinator can confirm that effective continuity of care protocol is being completed as the care coordinator advocates for and organizes the patient's care experience (Haggerty, Roberge, Freeman, & Beaulieu, 2013).

A continuity of care protocol can be implemented into healthcare organizations in the state of Alaska by creating a law mandating a specific continuity of care protocol be followed in all healthcare organizations for patients who identify as suicidal. This law would make effective continuity of care a requirement, instead of subjective and optional, increasing the likelihood of preventing suicide. The first step in creating such a law is through an initiative, which consists of three parts: an application, a petition, and an election (Alaska Division of Elections, 2016). The auxiliary guidebook included with this project provides information and resources helpful in completing an application to pursue an initiative mandating continuity of care in Alaska. The attached letters of support and proposed initiative is a call to action. The letters can be immediately sent to possible sponsors and glean support from Alaskans. The initiative has been developed based on research and can be included in the initiative application packet to

legislation. The goal of this project is not only to educate on the need for continuity of care for people who are experiencing suicidality, but also to see a step towards change. Ignorance is not bliss, rather ignorance leads to inaction, and in this case, death. Furthermore, being aware of an issue does not fix the problem, rather it is a starting point to address the problem. Now that the knowledge has been conveyed, action based on facts is possible. As said earlier by Knesper (2011), "Saving lives depends on how well 'the chain of survival' functions" (p. 25). Taking action and advocating for one of the missing links in Alaska's suicide prevention, continuity of care, could save a life.

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Appendix A

A Guidebook for Advocacy and Support of Mandating Continuity of Care between Medical Professionals and Behavioral Health Providers to Prevent Suicide in Alaska

A Guidebook for Advocacy and Support of Mandating Continuity of Care between Medical Professionals and Behavioral Health Providers to Prevent Suicide in Alaska

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Table of Contents

Introduction

The purpose of this guidebook is to create awareness and promote advocacy of continuity of care in Alaska – specifically the continuity of care between medical professionals and behavioral health providers and the need for legislation requiring such for suicide prevention. Continuity of care can be defined as a care provider communicating important clinical information directly with another care provider, ensuring patients have an easy transition between providers (Suicide Prevention Resource Center, 2013). Continuity of care is highlighted as an important procedure, as it can be very useful in suicide prevention (Hagen, Hjelmeland, & Knizek, 2017; Suicide Prevention Resource Center, 2013). Unsuccessful continuity of care has the potential to result in suicide among vulnerable patients (Hagen et al., 2017).

According to the State of Alaska Suicide Prevention Plan, 2018 – 2022 presented by Fishel and Walker (2017), Alaskans should have access to suicide prevention, treatment and other services immediately. However, Fishel and Walker (2017) provide no explicit plan for continuity of care between medical professionals and behavioral health providers for people who identify as experiencing suicidality. This is unacceptable given that primary care medical providers are in a matchless position to assess for suicidality in patients (Chesin, & Stanley, 2013; Gangwisch, 2010; Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014; Hooper, Epstein, Weinfurt, DeCoster, Qu, & Hannah, 2012; Niven, 2007; Vannoy, Fancher, Meltvedt, Unützer, Duberstein, & Kravitz, 2010). Medical professionals can actively help to prevent suicide by performing effective suicide assessments. A major concern, however, is that primary care practitioners are not routinely conducting suicide risk screenings (Chesin & Stanley, 2013; Gangswich, 2010; Hooper et al., 2012).

Suicide is a concern worldwide, impacting people from all cultures. The following statements are statistics regarding suicide:

- Approximately 800,000 people around the world commit suicide annually (World Health Organization, 2016).
- Approximately 44,193 United States citizens die annually by suicide (American Foundation for Suicide Prevention, 2017).
- An average of 121 suicides occur daily in America (American Foundation for Suicide Prevention, 2017).
- The state of Alaska has the second highest suicide rate in the nation (American Foundation for Suicide Prevention, 2017).
- Suicide is the leading cause of death among people ages 10 to 24 years old in Alaska. (American Foundation for Suicide Prevention, 2017).

Additionally, there is an extremely high rate of suicide among the Indigenous Alaskan population, a result of generational historical trauma since the colonization by non-Indigenous people to Alaska (Morgan & Freeman, 2009). This trauma stemming from colonization began between 1820 and 1840, almost 200 years ago, and was inflicted in multiple ways. Colonizers brought fatal diseases, against which Indigenous peoples of Alaska were not immunized. Colonizers forced Indigenous peoples of Alaska to become "civilized" by eliminating their culture, languages and religious beliefs (Morgan & Freeman, 2009). This "civilization process" was attempted by removing Indigenous Alaska peoples' children from their homes (sometimes through kidnapping) and placing them in boarding schools (Morgan & Freeman, 2009; Wexler, 2009). Note, this forced schooling took place as recently as the 1970s (Wexler, 2009). In these schools, Indigenous peoples of Alaska's children were denied contact with their families, and

were taught that all of their traditional ways were wrong (Morgan & Freeman, 2009; Wexler, 2009). As Alaska legally became a part of the United States, the Indigenous peoples of Alaska cultural oppression continued (Morgan & Freeman, 2009). This oppression caused a rise in mental health issues and suicide among Indigenous peoples of Alaska, which continues to this day (Axelsson, Kukutai, & Kippen, 2016; Morgan & Freeman, 2009; Lewis & Myhra, 2017); Wexler, 2009; Sullivan & Brems, 1997).

One way that Indigenous Alaskan peoples' historical trauma and resulting suicidality can be effectively addressed is through integrated care, the inclusion of behavioral health into medical care (Lewis & Myhra, 2017). Integrated care has been shown to increase continuity of care among Indigenous populations (Lewis & Myhra, 2017). Therefore, integrated care resulting in continuity of care is a significant way that patients who are experiencing suicidality can be helped. However, integrated care cannot be implemented effectively if medical providers are not aware of a patient's suicidality.

All medical professionals should be aware of suicide warning signs and consider them with all patients (Hooper, Epstein, Weinfurt, DeCoster, Qu, & Hannah, 2012). If the medical professional believes that the patient may be suicidal, a simple suicide screening can be completed. Some screenings can be a short as asking three questions, such as the Columbia-Suicide Severity Rating Scale (Substance Abuse and Mental health Administration, 2018). If patients answer positively for suicidality, a more in-depth suicide assessment can be completed. Suicide risk assessments are essential to determining who needs treatment, referrals, and resources (Gangwisch, 2010; Schulberg, Bruce, Lee, Williams, & Dietrich, 2004; U.S. Department of HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

After determining the patient has been experiencing suicidality, effective continuity of care can begin. In order to ensure that the patient is receiving consistent care throughout the transition process, a care coordinator can oversee the continuity of care process (Haggerty, Roberge, Freeman, & Beaulieu, 2013). A care coordinator advocates for and organizes the patient's care experience (Haggerty et al., 2013). Key aspects of an effective continuity of care protocol between medical professionals and behavioral health providers include, but is not limited to:

- Discharge planning
    - Contact patient's family and outside providers (Suicide Prevention Resource Center, 2013).
- Proactive follow-up (U.S. Department of HHS office of the Surgeon General and national Action Alliance for Suicide Prevention, 2012).
- Connections to community resources (U.S. Department of HHS office of the Surgeon General and national Action Alliance for Suicide Prevention, 2012).

Given the lethality of suicide, effective continuity of care should not be optional for medical professionals. In order to ensure that continuity of care is taking place between medical professionals and behavioral health providers in Alaska, a law should be created mandating continuity of care protocol.

Pursuing New Legislation in Alaska

According to the State of Alaska website regarding Alaska Division of Elections (2016), one method for creating a new law is through an *initiative.* An *initiative* is when a law is purposed by the state's constituents instead of those in the legislature. The initiative is subjected to several steps before it is even voted on: an application, a petition, and an election. The

application is where the initiative is proposed, which is filed with the lieutenant governor for a deposited fee of $100. The application must include the proposed bill, voter signatures, and initiative committee members. If the application is approved by the lieutenant governor, initiative petitions are distributed throughout Alaska, which are then filed. Finally, assuming the previous steps have been done correctly, the initiative will be placed on a ballot. A bill to propose as part of the initiative application is in the appendix to this guidebook (See Appendix A). Writing letters of support can be useful in the initiative proposal process (Nickell, 2017). Nickell (2017) suggests including four aspects in letters of support:

- Introduction of self and concern
- Research to support concern
- Proposed solution for concern
- Appreciative closing

Sample letters of support are provided in the appendix to this guidebook (See Appendices (B-E). The recipients of these letters include a variety of stakeholders in this project: Alaskan senator, Alaskan medical professional, Alaskan behavioral health provider, and Alaskan resident. Letters of support can prove useful in gaining voter signatures and increasing awareness among Alaskans.

Conclusion

A continuity of care protocol can be implemented into healthcare organizations in the state of Alaska by creating a law mandating a specific continuity of care protocol be followed in all healthcare organizations for patients who identify as suicidal. This law would make effective continuity of care a requirement, instead of subjective and optional, increasing the likelihood of preventing suicide. The goal of this project is not only to educate on the need for continuity of

care for people who are experiencing suicidality, but also see a step towards change. Ignorance is not bliss, rather ignorance leads to inaction, and in this case, death. Furthermore, being aware of an issue does not fix the problem, rather it is a starting point. Now that the knowledge has been conveyed, action based on facts is possible. As said by Knesper (2011), "Saving lives depends on how well 'the chain of survival' functions" (p. 25). Taking action and advocating for one of the missing links in Alaska's suicide prevention, continuity of care, could save a life.

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Appendix A

Continuity of Care Bill Proposal

MANDATE CONTINUITY OF CARE BETWEEN MEDICAL PROVIDERS AND BEHAVIORAL HEALTH PROFESSIONALS FOR PATIENTS WHO ARE EXPERIENCING SUICIDALITY

BE IT ENACTED BY THE PEOPLE OF ALASKA

An act mandating that medical professionals provide continuity of care for patients who identify as suicidal on a suicide assessment;

Whereas: continuity of care in this case is defined as communicating patient information directly with a behavioral health provider;

And whereas: the behavioral health provider must confirm that this communication took place, making a reasonable effort to communicate with the patient identified as suicidal;

And whereas: the state of Alaska currently has the second highest suicide rate in the nation;

And whereas: the State of Alaska Suicide Prevention Plan, 2018-2022 advocates for continuity of care without a plan or mandate for such;

And whereas: businesses staffing medical professionals and behavioral health providers who do not pursue continuity of care are fined a monetary amount.

And whereas: if a transition specialist is needed to aid in continuity of care, one will be provided by the State of Alaska, should grant funding allow it;

Appendix B

Sample Letter to Alaskan Senator Requesting Initiative Sponsorship

Date
Senator
State Capitol Room
Juneau, AK

Dear Senator,

My name is Mary Priest and I was born and raised in Fairbanks, Alaska. I am currently a graduate student at the University of Alaska Fairbanks, pursuing a Master's degree in community counseling. For my final project, I chose to advocate for a life-endangering concern: the lack of continuity of care between medical professionals and behavioral health providers for patients who are experiencing suicidality. I plan to engage in this advocacy work by proposing an initiative to Alaska legislation, requesting a mandate for effective continuity of care.

According to the Suicide Prevention Resource Center (2013), continuity of care takes place when a care provider communicates important clinical information directly with another care provider. The U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012) describes continuity of care in even greater detail, noting the need for proactive follow-up, connections to community resources, and the need for it to take place ideally within 48 hours of patient discharge.

I have lived in Alaska all my life, and truly understand the uniqueness of our state and Alaskans. I genuinely care about the welfare of all people, especially our younger generation. Suicide is a concern that impacts everyone, and has taken the lives of many of our young people. Although we have increased suicide prevention education efforts, we are missing a practical piece of active follow-up.

Below are a few of many research based facts which support my concern:

- The state of Alaska has the second highest suicide rate in the nation (American Foundation for Suicide Prevention, 2017).
- There were 201 deaths by suicide in Alaska in the year 2015 (American Foundation for Suicide Prevention, 2017).
- Suicide is the leading cause of death among people ages 10 to 24 years old (American Foundation for Suicide Prevention, 2017).
- In 2014, the rate of death by suicide for Alaska Native males was four times the national average, with 50.9 suicides per 100,000 (Alaska Bureau of Vital Statistics, 2018)
- Primary care medical providers are in a matchless position to assess for suicidality in patients (Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014).

- The first 30 days following discharge from an inpatient psychiatric unit or emergency department, the risk of another suicide attempt or death is at its greatest (Suicide Prevention Center, 2013).

The State of Alaska Suicide Prevention Plan, 2018-2022 states that strategy 2.6 is, "Health care providers understand how to recognize signs of suicide risk, talk with/screen patients about suicide, and *connect patients to appropriate treatment and support services*" (Fishel & Walker, 2017, p. 25, emphasis added). The strategy did not contain a plan on how patients are to be connected to the appropriate treatment and/or services. The only suggestion given was conducting "review screening questionnaires," which does not help patients once they have left the facility. Action needs to be taken to make this strategy a reality.

A solution to this concern is to propose an initiative to the Alaska legislature in the hopes of passing an act which mandates continuity of care. An initiative proposal is attached to this letter, summarizing continuity of care and its need in Alaska. Funding for this proposal can be gleaned from a variety of grants, designated toward suicide prevention. Suicide prevention is currently an important topic for our country, as the U.S. Surgeon General and the National Action Alliance for Suicide Prevention advocated the adoption of "zero suicide" (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). As the name implies, "zero suicide," promotes the goal to have zero suicides in an area. By supporting and sponsoring the attached initiative proposal for continuity of care, we can help Alaska reach this goal set by our state and nation's leaders.

Thank you for taking the time to read this letter, initiative, and for considering this request.

Respectfully,
Mary J.K. Priest
UAF Graduate Student
mary.jk.priest@gmail.com / Tel (907) 460-6626 / 1659 Old Pioneer Way, Fairbanks, AK 99709

References in Letter

Alaska Bureau of Vital Statistics. 2018. http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/AKSuicideStatistics2015.pdf.

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Appendix C

Sample Letter to Alaskan Medical Professional Requesting Initiative Support

Date
Alaskan Medical Professional
Address

Dear Medical Professional,

My name is Mary Priest and I was born and raised in Fairbanks, Alaska. I am currently a graduate student at the University of Alaska Fairbanks, pursuing a Master's degree in community counseling. For my final project, I chose to advocate for a life-endangering concern: the lack of continuity of care between medical professionals and behavioral health providers for patients who are experiencing suicidality. I plan to engage in this advocacy work by proposing an initiative to Alaska legislation, requesting a mandate for effective continuity of care.

According to the Suicide Prevention Resource Center (2013), continuity of care takes place when a care provider communicates important clinical information directly with another care provider. The U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012) describes continuity of care in even greater detail, noting the need for proactive follow-up, connections to community resources, and the need for it to take place ideally within 48 hours of patient discharge.

I have lived in Alaska all my life, and truly understand the uniqueness of our state and Alaskans. I genuinely care about the welfare of all people, especially our younger generation. Suicide is a concern that impacts everyone, and has taken the lives of many of our young people. Although we have increased suicide prevention education efforts, we are missing a practical piece of active follow-up.

Below are a few of many research based facts which support my concern:

- The state of Alaska has the second highest suicide rate in the nation (American Foundation for Suicide Prevention, 2017).
- There were 201 deaths by suicide in Alaska in the year 2015 (American Foundation for Suicide Prevention, 2017).
- Suicide is the leading cause of death among people ages 10 to 24 years old (American Foundation for Suicide Prevention, 2017).
- In 2014, the rate of death by suicide for Alaska Native males was four times the national average, with 50.9 suicides per 100,000 (Alaska Bureau of Vital Statistics, 2018)
- Primary care medical providers are in a matchless position to assess for suicidality in patients (Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014).

- The first 30 days following discharge from an inpatient psychiatric unit or emergency department, the risk of another suicide attempt or death is at its greatest (Suicide Prevention Center, 2013).

The State of Alaska Suicide Prevention Plan, 2018-2022 states that strategy 2.6 is, "Health care providers understand how to recognize signs of suicide risk, talk with/screen patients about suicide, and *connect patients to appropriate treatment and support services*" (Fishel & Walker, 2017, p. 25, emphasis added). The strategy did not contain a plan on how patients are to be connected to the appropriate treatment and/or services. The only suggestion given was conducting "review screening questionnaires," which does not help patients once they have left the facility. Action needs to be taken to make this strategy a reality.

A solution to this concern is to propose an initiative to Alaska legislation in the hopes of passing an act which mandates continuity of care. An initiative proposal is attached to this letter, summarizing continuity of care and its need in Alaska. Funding for this proposal can be gleaned from a variety of grants, designated toward suicide prevention. Suicide prevention is currently an important topic for our country, as the U.S. Surgeon General and the National Action Alliance for Suicide Prevention advocated the adoption of "zero suicide" (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). As the name implies, "zero suicide," promotes the goal to have zero suicides in an area. By supporting the attached initiative proposal for continuity of care, we can help Alaska reach this goal set by our state and nation's leaders. Suggested methods of support include emails, phone calls, and letters of support addressed to local Alaskan representatives and senators.

Thank you for taking the time to read this letter, initiative, and for considering this request.

Respectfully,
Mary J.K. Priest
UAF Graduate Student
mary.jk.priest@gmail.com / Tel (907) 460-6626 / 1659 Old Pioneer Way, Fairbanks, AK 99709

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Appendix D

Sample Letter to Alaskan Behavioral Health Provider Requesting Initiative Support

Date
Alaskan Behavioral Health Provider
Address

Dear Alaskan Behavioral Health Provider,

My name is Mary Priest and I was born and raised in Fairbanks, Alaska. I am currently a graduate student at the University of Alaska Fairbanks, pursuing a Master's degree in community counseling. For my final project, I chose to advocate for a life-endangering concern: the lack of continuity of care between medical professionals and behavioral health providers for patients who are experiencing suicidality. I plan to engage in this advocacy work by proposing an initiative to Alaska legislation, requesting a mandate for effective continuity of care.

According to the Suicide Prevention Resource Center (2013), continuity of care takes place when a care provider communicates important clinical information directly with another care provider. The U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012) describes continuity of care in even greater detail, noting the need for proactive follow-up, connections to community resources, and the need for it to take place ideally within 48 hours of patient discharge.

I have lived in Alaska all my life, and truly understand the uniqueness of our state and Alaskans. I genuinely care about the welfare of all people, especially our younger generation. Suicide is a concern that impacts everyone, and has taken the lives of many of our young people. Although we have increased suicide prevention education efforts, we are missing a practical piece of active follow-up.

Below are a few of many research based facts which support my concern:

- The state of Alaska has the second highest suicide rate in the nation (American Foundation for Suicide Prevention, 2017).
- There were 201 deaths by suicide in Alaska in the year 2015 (American Foundation for Suicide Prevention, 2017).
- Suicide is the leading cause of death among people ages 10 to 24 years old (American Foundation for Suicide Prevention, 2017).
- In 2014, the rate of death by suicide for Alaska Native males was four times the national average, with 50.9 suicides per 100,000 (Alaska Bureau of Vital Statistics, 2018)
- Primary care medical providers are in a matchless position to assess for suicidality in patients (Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014).

- The first 30 days following discharge from an inpatient psychiatric unit or emergency department, the risk of another suicide attempt or death is at its greatest (Suicide Prevention Center, 2013).

The State of Alaska Suicide Prevention Plan, 2018-2022 states that strategy 2.6 is, "Health care providers understand how to recognize signs of suicide risk, talk with/screen patients about suicide, and *connect patients to appropriate treatment and support services*" (Fishel & Walker, 2017, p. 25, emphasis added). The strategy did not contain a plan on how patients are to be connected to the appropriate treatment and/or services. The only suggestion given was conducting "review screening questionnaires," which does not help patients once they have left the facility. Action needs to be taken to make this strategy a reality.

A solution to this concern is to propose an initiative to Alaska legislation in the hopes of passing an act which mandates continuity of care. An initiative proposal is attached to this letter, summarizing continuity of care and its need in Alaska. Funding for this proposal can be gleaned from a variety of grants, designated toward suicide prevention. Suicide prevention is currently an important topic for our country, as the U.S. Surgeon General and the National Action Alliance for Suicide Prevention advocated the adoption of "zero suicide" (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). As the name implies, "zero suicide," promotes the goal to have zero suicides in an area. By supporting the attached initiative proposal for continuity of care, we can help Alaska reach this goal set by our state and nation's leaders. Suggested methods of support include emails, phone calls, and letters of support addressed to local Alaskan representatives and senators.

Thank you for taking the time to read this letter, initiative, and for considering this request.

Respectfully,
Mary J.K. Priest
UAF Graduate Student
mary.jk.priest@gmail.com / Tel (907) 460-6626 / 1659 Old Pioneer Way, Fairbanks, AK 99709

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Appendix E

Sample Letter to Alaskan Resident Requesting Initiative Support

Date
Alaskan Resident
Address

Dear Alaskan Resident,

My name is Mary Priest and I was born and raised in Fairbanks, Alaska. I am currently a graduate student at the University of Alaska Fairbanks, pursuing a Master's degree in community counseling. For my final project, I chose to advocate for a life-endangering concern: the lack of continuity of care between medical professionals and behavioral health providers for patients who are experiencing suicidality. I plan to engage in this advocacy work by proposing an initiative to Alaska legislation, requesting a mandate for effective continuity of care.

According to the Suicide Prevention Resource Center (2013), continuity of care takes place when a care provider communicates important clinical information directly with another care provider. The U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012) describes continuity of care in even greater detail, noting the need for proactive follow-up, connections to community resources, and the need for it to take place ideally within 48 hours of patient discharge.

I have lived in Alaska all my life, and truly understand the uniqueness of our state and Alaskans. I genuinely care about the welfare of all people, especially our younger generation. Suicide is a concern that impacts everyone, and has taken the lives of many of our young people. Although we have increased suicide prevention education efforts, we are missing a practical piece of active follow-up.

Below are a few of many research based facts which support my concern:

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- There were 201 deaths by suicide in Alaska in the year 2015 (American Foundation for Suicide Prevention, 2017).
- Suicide is the leading cause of death among people ages 10 to 24 years old (American Foundation for Suicide Prevention, 2017).
- In 2014, the rate of death by suicide for Alaska Native males was four times the national average, with 50.9 suicides per 100,000 (Alaska Bureau of Vital Statistics, 2018)
- Primary care medical providers are in a matchless position to assess for suicidality in patients (Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014).

- The first 30 days following discharge from an inpatient psychiatric unit or emergency department, the risk of another suicide attempt or death is at its greatest (Suicide Prevention Center, 2013).

The State of Alaska Suicide Prevention Plan, 2018-2022 states that strategy 2.6 is, "Health care providers understand how to recognize signs of suicide risk, talk with/screen patients about suicide, and *connect patients to appropriate treatment and support services*" (Fishel & Walker, 2017, p. 25, emphasis added). The strategy did not contain a plan on how patients are to be connected to the appropriate treatment and/or services. The only suggestion given was conducting "review screening questionnaires," which does not help patients once they have left the facility. Action needs to be taken to make this strategy a reality.

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Thank you for taking the time to read this letter, initiative, and for considering this request.

Respectfully,
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